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**The Connecticut Association of Not-for-profit Providers For the Aging**

**Testimony to the Select Committee on Aging**

**Regarding**
***Senate Bill 488, An Act Concerning the Method of State Reimbursement to Nursing Homes***

**March 3, 2009**

**Presented by Mag Morelli, CANPFA President**

Good morning Senator Prague, Representative Serra, and members of the Committee. My name is Mag Morelli and I am the president of the Connecticut Association of Not-for-profit Providers for the Aging (CANPFA), an organization of over 150 non-profit providers of aging services representing the full continuum of long term care.

CANPFA promotes a vision of the world in which every community offers an integrated and coordinated continuum of high quality, affordable health care, housing and community based services. The CANPFA membership includes fifty not-for-profit skilled nursing facilities, many of which operate within such a continuum, and therefore I would like to comment on *Senate Bill 488, An Act Concerning the Method of State Reimbursement to Nursing Homes.*

We commend the committee for raising this bill and initiating a debate on the appropriate reimbursement methodology for skilled nursing facilities where care is provided to our most frail citizens.

CANPFA has been studying the current reimbursement methodology in an attempt to find a more sustainable system that will adequately provide for quality care, be fair to all providers and be affordable to the state. This is not an easy task and when we began to review the various reimbursement options, we realized that our current statutory system of reimbursement is actually a fairly good system.

Our statutory rate setting system is fair to the providers because it recognizes and reimburses the allowable costs of providing care. It is fair to the state because it places parameters on those costs to recognize only those which are deemed "allowable" and then caps those cost centers so as to encourage efficiencies. Through the fair rent component it encourages capitol investment in physical plant and it can encourage investment in updated resident care equipment. And it incorporates a timely method of rate recalculation (through rebasing) to keep up with both inflation and the changes that occur in health care technology and practice.

If it were allowed to work as it is statutorily prescribed, our current rate setting system would also recognize costs associated with providing quality resident care including specialized programming, advanced technologies, and the higher costs of caring for higher acuity residents.

The problem is not with our current rate system. The problem is the fact that we have not allowed that system to work.

Year after year the legislature overrides the statute and instead implements a small inflationary rate increase or, as it did last year, no increase at all. By ignoring the statutory rate system, the legislature has instead created an alternative system that forces a nursing home in financial need to appeal to the Department of Social Services for an interim rate. Rate setting has become a process of one by one, individual determinations of interim rates while the system as a whole falters. Financial distress is rewarded while incentives to run an efficient home, to invest in the physical plant, to purchase new equipment, to increase or maintain staffing levels, are lost.

The reason the state has not allowed the rate setting system to work as prescribed in statute is because it has not been able to fund it. Therefore the issue we really need to address is how to adequately finance our long term care system – the whole system, not just the nursing home component. This is not just a state issue. This is a national issue. That is why our national affiliate organization, the American Association of Homes and Services for the Aging (AAHSA), has spent the last several years studying it and has presented a solution that they believe may work on a national level. I have included some of the information on this Long Term Care Solution with this testimony for your information.

The bill before you today asks the Commissioner of Social Services to develop a plan to establish a rate setting structure based on a prospective case-mix payment. This system presumably would provide a nursing home an established rate based on a resident's diagnosed condition. While this case-mix rate setting structure may have merit, we are very concerned that unless we address the root problem of how to adequately fund the system, redesigning the rate setting structure will only be used as a means of reducing reimbursement to providers and will solve nothing.

That said, we recognize there is a problem and believe that providers must be part of the solution. We therefore would be eager to discuss and work on these issues with the committee, the commissioner, and any other interested parties.

Thank you for your consideration of this testimony.

**Mag Morelli, President**

**CANPFA, 1340 Worthington Ridge, Berlin, CT 06037 (860)828-2903 morelli@canpfa.org**

# Modeling a New Long-Term Care Financing Framework: Moran Company Report on the AAHSA Long-Term Care Solution

The Long-Term Care Solution Project
Of the American Association of Homes and Services for the Aging

## The Vision

The United States does not have a comprehensive, fiscally sound approach to financing long-term care. The sheer size of the pending age wave of baby boomers will overwhelm Medicaid and other health and social service programs. Currently, Medicaid is the primary payer for long-term care services for elderly with low-incomes and individuals with disabilities. If we do nothing, the increasing burden on individuals and families and on state and federal programs-Medicaid, in particular, is unsustainable.

Mindful of the fact that our nation lacks a rational long-term care financing system, the American Association of Homes and Services for the Aging (AAHSA) developed the Long-Term Care Solution, an actuarially sound national insurance trust. Guided by the interests of consumers, The Solution is based on three core principles: consumer choice, financial responsibility and equity. Consumers will have choices in the types of services they can receive. Americans will take personal responsibility for their anticipated long-term care needs. Those who can afford premiums will pay while people with very low incomes will continue to receive help with premium payments. Benefits will be available to all adults.

With the framework identified, AAHSA retained the Moran Company, a nationally known economic consulting firm, to carry out the economic modeling. The modeling confirms that there is an affordable national solution.

## The Project

The Moran Company constructed a financial model to determine the premium costs for an actuarially sound public long-term care insurance plan proposed by AAHSA. The plan is "fully funded," meaning that the premiums (and earned interest on investments) cover the full cost of benefits and do not add to the federal deficit. To simplify the modeling, the plan is assumed to be mandatory.

## Premium Prices for the New Insurance

The Moran Company explored various scenarios for plan details and estimated premium prices using two different assumptions regarding disability rates, which are key drivers of costs. The chart below shows premium prices for a program that includes everyone age 21+, has a five year vesting period, and pays $75/day to people with qualifying disabilities (2+ ADLs). Various numbers of covered benefit years are shown. For example, **a plan that paid for just one year of benefits would cost participants $0.73/day in premiums; a plan that paid for a lifetime of benefits would cost $2.87/day in premiums.**

| Number of Benefit years covered | High (premium price assumes high rates of disability) | Medium (premium price assumes medium disability rates) | Mid Point Annual | **Premium Costs Per Day** |
|---|---|---|---|---|
| 1 | $318 | $213 | $266 | **$0.73** |
| 2 | $557 | $373 | $465 | **$1.27** |
| 3 | $717 | $490 | $614 | **$1.66** |
| 5 | $971 | $641 | $806 | **$2.21** |
| **Lifetime** | $1270 | $826 | $1048 | **$2.87** |

**Effect on Medicaid LTC Expenditures**

The Moran Report estimates that **Medicaid could have saved about half of all its LTC costs, had the lifetime AAHSA program (outlined above) been operating in 2005** (the most recent year for which detailed information on Medicaid LTC costs is available). Potential savings would be less if the new insurance covered fewer benefit years because more disabled people would have exhausted their benefits in any one year and would still need to rely on Medicaid, if poor.

| Number of Benefit Years that the insurance plan covers | **Medicaid: Potential reduction in Federal & State LTC Medicaid spending due to the availability of the LTC insurance program (Billions)** | Percent of Total Medicaid spending on LTC (Federal & State) | Percent of people with 2+ADLs who are actually collecting benefits in any one year |
|---|---|---|---|
| 1 | $11.4 | 12% | 22.2% |
| 2 | $20.3 | 21% | 39.5% |
| 3 | $27.1 | 29% | 52.8% |
| 5 | $36.3 | 38% | 70.7% |
| **Lifetime** | **$47.7** | **50%** | **92.9%** |

On the following pages you can read the complete report by the Moran Company, *Modeling a New Long-Term Care Financing Plan* (December, 2007). For a detailed report on the Long-Term Care Solution Project visit: http://www.thelongtermcaresolution.org/Files/Framework.pdf